South Carolina Department of Disabilities and Special Needs

PDD Program Consumer Insurance Verification

Date: _____

Consumer's Name: _____

Consumer's Social Security Number: _____

_____ **The above referenced child is not covered by an insurance carrier who will/can provide behavioral therapy (i.e. ABA) services as stipulated under Ryan's Law.**

_____ **The above referenced child is covered by an insurance carrier who will/can provide behavioral therapy (i.e. ABA) services as stipulated under Ryan's Law.**

Please list the provider's name, telephone number and Fax number:

_____

_____

How many hours of service per week does your child receive from this provider?

_____/_____/_____

Consultant Lead Therapy Line Therapy

ATTESTATION

This document must be completed and returned to the Case Manager in order to continue pursuing your child's participation in the PDD Program. By signing this document, you acknowledge and affirm that the information you have provided concerning your child is true and correct to the best of your knowledge. Furthermore, you agree to inform the Case Manager should your child's insurance status change.

_____

Parent/Legal Guardian Signature Date

Original: Participant's File Copy: Parent/Legal Guardian, PDD Waiver Coordinator and District Autism Staff

PDD Form 42 June 7, 2010